Conclusion

To develop long-range options for the TDH hospitals, public health and clinical benefit and financial and public expectation impact factors were developed in coordination with TDH management which included budget, personnel, program managers, and clinical experts. In addition, considerable review of the third State managed hospital with TB services operated by UTHC-Tyler was conducted to examine the potential for integrating the State's TB control efforts.

Long-range options are judged against an understanding of the costs, benefits and impact as well as an understanding of tuberculosis control efforts.

From 1970 through 1980 TB cases reported in Texas decreased an average of 3% per year. However, TB cases began to increase in the mid-1980's continuing until 1994, when the number of cases reached a twenty year high of 2,542 and a case rate of 12.7 per 100,000. Since 1994, though, control of TB appears to have been restored, and a declining number of cases in being seen. The prevalence of multidrug resistant TB (MDRTB) in Texas and Mexico has created significant public health risks and is requiring improved treatment efforts. Approximately 30% of TB treatment in Texas is for foreign-born patients.

To augment the provision of TB inpatient hospital care provided by local public hospitals and private hospitals throughout the State, the State of Texas manages three hospitals with specialized inpatient facilities to treat TB. Two are managed by TDH and one is managed by UTHC-Tyler. Since the TDH hospitals tend to treat patients who are almost exclusively medically indigent, it is probable that demand will continue for the TB patient population which has traditionally been served by the TDH hospitals. Because of the heavy medically indigent case load, the two TDH hospitals are able to qualify for millions of Medicaid DISPRO federal dollars ($19.6 million for 1998). From 1998 through 2002, it is estimated that the TDH hospitals will generate over $85 million of Medicaid DISPRO payments of which approximately $54 million are federal funds.

There are complexities which impact estimating total demand for State managed inpatient beds for confirmed TB cases. Data indicates that public and private hospitals in most areas of the State are providing the short term and emergency inpatient hospital services to persons infected with TB. However, for many persons who require long lengths of stay, the State managed hospitals are the safety net providers. For example, of the total number of TB cases in Texas in 1997 (1,992), approximately 270 cases resulted in hospitalization in TDH hospitals which maintained a combined average daily census of 87 TB patients. Estimating inpatient bed needs for the future assumes that the existing public and private hospital support for inpatient TB care will continue and that the State will continue to address the population which during the past five to ten years has relied upon the State managed TB hospitals.

It is noted that the ability of hospitals to continue to provide inpatient services to persons who are medically indigent could be adversely affected in the next decade if DISPRO funding is materially reduced. Even though most recent trends indicate TB cases are declining which

should indicate fewer admissions, the multiple-drug resistant cases are expected to increase the overall average hospital length of stay for those that are admitted.

To create a long-range plan options were developed and examined against the benefit and impact criteria. Options A through F which have been described in this report appear to include all available alternatives pursuant to Rider 44.

Discussion should now begin to assure understanding of all options and the complex issues associated with the decision process. These additional discussions will enhance understanding and may result in variations on the options described. A best option should emerge for consideration during the legislative process.

The chosen option should promote an integrated State administered inpatient TB management strategy to encourage a seamless safety net provision of TB patient care which incorporates medical education, research, and improved quality of care while allowing for the State to continue to generate the substantial DISPRO federal funds for the benefit of the State's general fund.

During the course of this study several other government initiatives were identified which may affect strategic planning for these hospitals and particularly may necessitate revisiting the phase-in of the renovations recommended for the STH. Since these initiatives are still in the development phases and they should be monitored. They include such things as development of the Regional Academic Health Center initiative in the Lower Rio Grande Valley which the University of Texas Board of Regents is scheduled to decide during the fall of 1998; the Brooks Air Force Base/San Antonio study initiative to more effectively use the Brooks Air Force Base site; TDMHMR facility evaluations Binational TB elimination efforts which may include inpatient hospital initiatives in Mexico and redefining binational TB authority; the potential for regional TB centers coordinated with the federal Centers for Disease Control and Prevention; and the effects of implementation of the Immigration Reform Act.

This study leads to a strong conclusion that the State of Texas does not have an easy course to pursue. TB is the world's number one communicable disease killer and will remain a major, costly health care challenge for the foreseeable future. For Texas the problem is accentuated by our proximity to Mexico with its extremely high rate of TB infection and multiple drug resistant TB. The necessary steps and concomitant outlay of funding, to assure timely, clinically appropriate intervention and treatment of TB must be forthcoming in the short term.